

## DEPARTMENT OF HEALTH SERVICES

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June 29, 1999

Ms. Kathleen Farrell  
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Division of Integrated Health Systems  
Health Care Financing Administration  
7500 Security Boulevard, Mail Stop S2-01-16  
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Dear Ms. Farrell:

SECTION 1115 WAIVER MEDICAID DEMONSTRATION PROJECT FOR  
FAMILY PACT (FAMILY PLANNING, ACCESS, CARE, and TREATMENT) PROGRAM

This letter conveys our response to the questions regarding the Family PACT Program Waiver Proposal that were raised in the May 28, 1999, letter from Mr. Mike Fiore of the Health Care Financing Administration (HCFA). To make the response orderly and thorough, we have duplicated in italic type sections of that letter and its enclosure and followed them with our response. We have also enclosed materials that elaborate our answers and provide supporting documentation.

**Letter Topics****1. Budget Neutrality and Demonstration Objectives**

**Q** *The budget neutrality methodology in section 1115 family planning demonstrations is based on a pre-post comparison of fertility rates. The pre-period fertility rate would reflect actual recent experience among women who would be SOBRA-eligible if they were pregnant. The fertility rate during the demonstration will reflect actual pregnancy experience of demonstration participants. The pre-period rate is calculated using the number of deliveries among Medicaid SOBRA eligibles for the numerator and the number of women within the SOBRA income band for the denominator. The denominator requires a population count based on income, which necessitates using the State data resources or results of other data collections such as the Census. We would like to discuss with you the selection of a year to be used for the pre-period fertility rate for which appropriate information is available. Also, the with-waiver and without-waiver budget projections in the proposal should be revised to reflect a pre-post comparison of fertility.*

- A The Family PACT Program as proposed in this waiver is the latest step in the continuing growth in the provision of family planning services for the indigent population in California during the last 25 years. As such it is not possible to truly determine the fiscal impact of the proposed waiver program solely based on the birthrate for the impacted population immediately prior to the waiver and during or at the end of the waiver period. The real impact of such a program is the number of unwanted pregnancies and births that are averted by ensuring the continuation and growth of family planning services. This is what the budget neutrality calculations in the proposed waiver request provide. They identify the cost that would occur, if the project services were not available.

We recognize the need for benchmark data to utilize in HCFA's management and evaluation of this family planning services demonstration project. We propose that at midway through the project period, the State and HCFA conduct a study using 1997 as the base year to determine a pre-waiver birthrate and a projected post-waiver birthrate. Project evaluations could then be based upon this data.

- Q *The cost of the eligibility expansion for family planning services must be offset by program savings resulting from a successful demonstration intervention, which would reduce fertility rates. In order for an intervention to occur there must be a demonstrated engagement of people not currently seeking family planning services or an improvement in access to services for people who are unsuccessfully seeking services. Simply substituting demonstration funds for Title X or State-only funds will not reduce fertility rates. What program expansion and changes will occur as part of the section 1115 demonstration? The expansions and changes should be reflected in the post-period fertility rate.*

- A As a result of renewed focus on the population eligible for the Family PACT program, California expects to clearly show an increase in access to family planning services by members of this target group. Additionally, in an effort to increase access to this underserved population, a campaign to sign on new providers in medically underserved areas will be implemented. The combination of focus on this population in California's medically underserved areas, as well as the campaign to increase the number of providers serving them, is expected to result in a noticeable increase in access to family planning services and a resulting increase in the provision of services. This increased access to and utilization of services will contribute to a reduction in the unintended birthrate.

## 2. Eligibility Determination

- Q *We are committed to working with you to reach resolution on issues regarding the*
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*(Family) PACT eligibility determination process. . . . We have scheduled a call with your staff on June 3 to discuss possibilities for waivers to allow the State as much flexibility as possible in its eligibility determination process.*

- A While we understand your concerns with regard to the requirement that eligibility determination must be made by a State merit employee, one of the major features of the Family PACT Program is the ability to determine eligibility at the point of service. We have requested waiver of Social Security Act Section **1902** (a)(5) in the waiver application and reiterate our request for a waiver of the requirements of this Social Security Act provision.

Onsite client eligibility is one of the key features of Family PACT and is the fundamental component of the program which eliminates barriers to access to family planning services. We would like to emphasize that this proposed waiver project is for a very limited, yet very cost-effective, scope of services, and is not proposing point of service eligibility determinations for a full-scope Medicaid program.

The onsite client eligibility process is detailed in the enclosed Family PACT Policies, Procedures and Billing Instructions (PPBI) Section 2, (page **2-1** through **2-18**). The process addresses:

- Client eligibility criteria
- Provider responsibilities
- Client responsibilities
- Eligibility verification
- Eligibility period and re-certification
- Certification records and confidentiality
- Notice of eligibility determination
- Fair hearing rights
- Forms
- Client notification
- Instructions for completion of the Client Eligibility Certification Form (**DHS 4461**)
- Eligibility information: Family size and income
- Client eligibility certification codes
- Determination of eligibility
- Gross family income definition
- Income eligibility guidelines

Section 1 of the PPBI (pages 1-2 and 1-3) details the enrollment process for Family PACT providers. The referenced Family PACT Application and Enrollment Agreement (enclosed) includes the following statement:

“...to commit all Service Sites, Provider Numbers and Practitioners specified in this Application and Agreement to the Practice Information, Administrative Practices and Clinical Practice Standards (Attachment 2), which is incorporated in this Application and Agreement by reference. . . .”

The Family PACT clinician provider, through the Application and Enrollment Agreement, accepts the responsibility for appropriate determination of eligible clients according to program guidelines described in the PPBI, Section 2.

To certify a client's eligibility for Family PACT, all information collected on page 1 of the Client Eligibility Certification form (PPBI page 2-9) is submitted electronically to a beneficiary data base maintained by the Medi-Cal Program fiscal intermediary, Electronic Data Systems (**EDS**). At each visit, the clinician provider must verify that the client is still eligible. The clinician provider must also re-certify client eligibility at least annually (PPBI page 2-19).

Because of the sensitive and discretionary nature of family planning services, clients are particularly wary of any process that might compromise the confidentiality of such services. Requiring additional documentation of client eligibility criteria could present significant access barriers to a large number of potential patients. The State believes that the onsite client eligibility process referenced above and implemented by Medi-Cal providers who have completed the provider enrollment requirements for Family PACT, provides sufficient accountability and significantly promotes access to services to justify waiving federal requirements in conflict with this process.

### 3. Immigrants

**Q** *The current application and eligibility process does not have a mechanism for differentiating among immigrants who would not be eligible for the (Family) PACT program. The (Family) PACT program must be considered a “means-tested benefit” according to the interpretation of the term as published in the Federal Register on August 26, 1997. As such, the restrictions on coverage of immigrants that apply under the provisions of Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended by the Balanced Budget Act of 1997, would apply to this program. The State has suggested a sampling technique to identify the percentage*

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*of costs attributable to illegal aliens. This amount — 10 percent as recommended by the State — would then be deducted from the amount claimed for Federal match. We are looking into the State's percentage proposal and will discuss this with your staff on June 3.*

- A The concept of disregarding a portion of the costs that represents a similar portion of the population of clientele has previously been accepted by HCFA. The amount of the disregard, 10 percent, is a generous amount. The percentage is inferred from the sampling conducted for the Los Angeles County Section 1115 Demonstration Waiver that employed a HCFA approved sampling methodology. Considering that the Family PACT Program is serving a statewide population, we believe that the proportion of the statewide ineligible immigrant population to be served is low and much lower than the patient population served at Los Angeles County-owned facilities.

#### 4. Individuals with Other Insurance

- Q . . . *individuals can still be program-eligible if they have health insurance coverage that includes family planning services, should they express concerns regarding confidentiality in receiving services through their current insurer. While we understand the State's concern for assuring access to services to low-income clients, we are concerned about providing services to people who already have health coverage.*

- A We understand your concerns regarding provisions of Family PACT services to persons who already have insurance coverage. However, we are confident that the Family PACT Program eligibility process does address criteria related to other insurance coverage.

Family PACT is a payor of last resort. Family PACT does not pay for family planning services for clients who are able to receive such services via other health insurance coverage. The PPBI, pages 2-1, 2-2, 2-12, and 2-18, specify those eligibility criteria related to other insurance coverage. These paragraphs describe the provider's obligation to clarify whether a client is able to obtain family planning services via other health insurance programs.

Our concerns with regard to the provision of Family PACT services to clients who may have other insurance is related to women accessing these services because they wish to maintain the confidential use of family planning services. Their marital status, culture, or other personal circumstances may play an important role in the confidentiality of accessing family planning services. Beneficiaries of the Family PACT program include an exceptionally large pool of culturally and ethnically diverse people. This diversity,

combined with the sensitive nature of family planning services, oftentimes underscores the need to ensure client confidentiality. As specified in these criteria, access to family planning services via other health insurance systems can be negated if such access eliminates confidentiality for clients.

#### **HCFA Enclosure: Request for Additional Information**

##### Evaluation

**Q** *What type of evaluation/assessment work is already being conducted on the impact of the (Family) PACT program? Is there any preliminary information available?*

**A** University of California, San Francisco (UCSF), under contract with the California Department of Health Services Office of Family Planning (OFP) is conducting an evaluation of the Family PACT program. This evaluation assesses the efficacy and efficiency of Family PACT in providing family planning services to low income women and men in California. The evaluation is multifaceted and will utilize a variety of survey and observational methodologies to collect data. Copies of the data collection instruments are attached for review. The methodologies include:

1. An analysis of program claims data to determine the scope of delivered services, patterns of service delivery, potential cost shifting, and over-and under-utilization of services; to perform fiscal forecasting; and to assist in the identification of operational problems.
  2. Beneficiary exit interviews to determine satisfaction with and perceptions of the program.
  3. Site visits to observe education and counseling to determine adherence to program standards and the ability of the services to meet client need.
  4. A survey of enrolled Family PACT providers to determine perceptions of and satisfaction with the program and to identify operational problems.
  5. A survey of Family PACT providers who delivered services under previous programs administered by the Office of Family Planning to determine impact of the new program on services and to determine perceptions and levels of satisfaction with the new program.
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6. An analysis of the impact of Family PACT screening and treatment for sexually transmitted infections (STI) on STI prevalence and incidence, and cost savings in pelvic inflammatory disease (PID) and dysplasia services.

OFP and UCSF concur with the need to assess the program's success in engaging people not currently seeking family planning services or the improvement in access to services to people who are unsuccessfully seeking services. The next phase of the evaluation project may include, but will not be limited to, the following:

1. An analysis of barriers to accessing family planning services among women and men not participating in Family PACT.
2. An analysis of access to services among Family PACT clients who continue to have unmet family planning needs.
3. A more comprehensive assessment of adherence to the program's standards of care and the quality of delivered services.
4. Assessment of the efficiency and effectiveness of resource oversight strategies in the identification and prevention of fraud and abuse within the program.
5. An analysis of the impact of Family PACT screening and treatment for STI on STI prevalence and incidence, and cost savings in PID and dysplasia services.

Preliminary information beyond the beneficiary and provider data presented in the waiver application is not currently available. It is expected that a **draft** of the evaluation report will be presented to OFP by UCSF in November of 1999.

**Q**     *What hypotheses are being investigated?*

**A**     The main hypotheses being investigated include:

- The Family PACT program increases access to family planning services for men and women residing in California.
  - Deregulation has not adversely impacted adherence to the Family PACT program standards of care or the quality of delivered services.
  - The family planning services delivered through the Family PACT program have impacted the number of unintended pregnancies in California.
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**Q** *How will the evaluation account for/distinguish Family PACTS success versus Medi-Cal family planning services if clients may be on/off both programs?*

**A** The current evaluation is limited to Family PACT clientele. For those limited clients who cross-over between both the Family PACT and Medi-Cal programs, it will be difficult to truly distinguish which program had the successful intervention.

**Q** *What will be measured in the beneficiary and provider surveys?*

**A** Please see the response above.

#### Target Population

**Q** *How are individuals expected to roll in or out of the program over its 5-year project period?*

**A** Clients become enrolled and disenrolled in the Family PACT program based on established eligibility criteria. Eligibility criteria are described in the PPBI, pages 2-1, 2. Providers are required to validate a client's eligibility for Family PACT at each visit and to renew a client's eligibility on an annual basis (PPBI, page 2-19). Providers electronically verify an enrolled client's eligibility via the HAP card number. Client's are expected to "roll in or out" of the Family PACT program based on changes in their personal and/or economic status such as changes in income, expansion/elimination of insurance coverage, becoming pregnant, etc.

**Q** *What information is available on the service and contraceptive utilization patterns of clients currently enrolled in the Family PACT program?*

**A** The State contracts with the UCSF Center for Family Planning Research, for analysis of the Family PACT utilization and demographics data collected. Preliminary data of client

encounters by primary diagnosis codes, during FY 1997-98, show the following family planning service utilization:

ContraceptiveMethod	Client Encounters	
oral contraceptives	630,980	42%
contraceptive injections	298,726	20%
barrier methods	309,200	21%
pregnancy testing (only)	134,798	9%
IUD	64,546	4%
contraceptive implants	18,629	1%
fertility evaluation	17,465	1%
tubal ligation	14,261	1%
vasectomy	3,000	0.2%

Additional data regarding the Family PACT program's objective of increasing the use of more effective contraceptive methods is being collected and analyzed.

- Q

*What data is available on the service utilization patterns for male clients? Must a male client be a partner of a potentially SOBRA-eligible female in order to enroll?*
- a

Males served within the Family PACT program constitute five percent of the client population. Male clients do not have to be a partner of a female client enrolled in Family PACT. Males are enrolled at the provider site based on the same residency, income and lack of medical insurance eligibility requirements as female clients. Services to males can include health education and counseling, provision for barrier methods, presumptive treatment of sexually transmitted infections, HIV counseling and testing, and vasectomy services. Data reflecting utilization patterns by male clients is being compiled and will be available in FY 1999-2000. However, data from FY 1997-98 indicates that 3,000 client encounters were for vasectomies.
- Q

*What are the enrollment figures for each month, i.e., unduplicated count?*
- A

The monthly enrollment figures for new Family PACT program clients is provided on the enclosed table: Number of New Family PACT Client Enrollments; 1/1/97-1/31/99.
- Q

*Please provide a detailed description of the annual renewal process. Is there a review of a renewal application? If so, who does the review? Since a client is not restricted from receiving family planning services from one Family PACT provider, who is responsible for recertifying the clients' eligibility if they are receiving services from multiple providers?*

- A Pages 2-5 and 2-6 of the PPBI describe the client recertification process in detail. At the time of initial enrollment, all clients receive a HAP card with a unique identifiable number. Providers include a client's HAP card number whenever Family PACT service claims are submitted. A client's HAP card must be re-certified annually; this recertification may be done on-site by any Family PACT provider. It is the responsibility of the medical provider to update the eligibility information through the automated HAP Client Eligibility System. After the client completes a new Client Eligibility Certification form, enrollment may be completed through the Point of Service (POS) device, the Automated Enrollment Verification System (AEVS) or the Internet client enrollment system. A client can receive Family PACT services from any Family PACT provider by presenting a valid HAP card. The HAP card number is an index key to track clients in the Family PACT data files. These files are monitored by UCSF Evaluation Team as well as by the Medi-Cal Payment Systems Division (PSD).

#### Provider Network

- Q *Please discuss any outreach/education plans for trying to improve the level of services that are provided in the private sector.*
- A Family PACT has initiated several mechanisms to both increase and improve services by private providers:
- Family PACT has an ongoing recruitment program that includes full day orientation sessions that are conducted twice a month throughout the State. These sessions are prominently posted in Medi-Cal provider bulletins and continue to be well attended by both public and private providers.
  - Through a training and recruitment contract, perinatal providers have been targeted for recruitment. Pregnant women between 100 percent and 200 percent poverty can be covered by Medi-Cal only until the baby is born. Subsequent to the perinatal period, OB-GYN providers can maintain these established clients as family planning clients if they become Family PACT providers.
  - Private providers in rural areas are a targeted population for Family PACT recruitment. The program has developed a specialized on-site orientation and enrollment process for these providers to address the oftentimes significant problems of attending more geographically centralized orientation/enrollment sessions.
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- In the spring of **1999**, Family PACT established the Family PACT Provider Support Network (FPPSN) to address quality of care issues. The FPPSN includes five organizations focused on different aspects of family planning. In April, May, and June **1999**, the FPPSN provided twenty-four different training events to enhance the quality of reproductive health services delivered by both public and private Family PACT providers. The Provider Support Events Calendar (attached) references the date, place and topics of each of these events. The FPPSN is currently in the process of establishing a training events calendar for FY **1999-2000**.

**Q** *Are pediatricians utilized to serve teens?*

**A** Pediatricians are Family PACT providers for some of the teen clients. Teens are also served by general practice and family practice, private and public providers.

**Q** *How many providers participating in the 65 Title X agencies (in 200 service sites) are also Family PACT providers?*

**A** All of the Title X family planning providers are enrolled in the Family PACT program. Title X providers represent approximately **200** of the **2400** Family PACT providers. We would like to emphasize that the Title X grantee (California Family Health Council, Incorporated) and its provider agencies are “last dollar” funding for family planning services in California in accordance with Department of Health and Human Services, Code of Federal Regulations **45**, Program Income section **74.24(b)(3)**. The **\$20** million grant is allocated among many activities: community outreach, community education, marketing, development of collaborations, infrastructure support, and clinical services. These efforts target special populations such as homeless, substance abusers, persons with disabilities, adolescents and men. Persons with incomes up to **250** percent of the federal poverty level are eligible for these Title X services.

**Q** *How is a client informed of available providers?*

**A** The State has a toll free telephone number for clients to locate a Family PACT provider in their geographic area [**1 (800) 942-1054**]. This is an automated system available in English and Spanish and will give limited health information and refer a client to a local provider based on a telephone prefix.

**Q** *What type of outreach/marketing does the state or providers conduct to potential enrollees?*

- A Family PACT has implemented several outreach/marketing strategies for potential enrollees. These include:
- Collaboration with the State Department of Social Services to publicize Family PACT at local social service sites throughout the State. A brochure focusing on family planning and Family PACT has been developed and is available for distribution at all local social service offices.
  - Developing posters and client information panel cards available free to Family PACT providers to market the program in local communities.
  - Collaborating with California's Comprehensive Perinatal Services Program to educate perinatal service coordinators about the Family PACT Program.
  - The State has awarded a contract to the California Family Health Council (the Title X administrator) to conduct a Family PACT media and outreach campaign to increase awareness of the program by potential beneficiaries. This campaign is currently being developed and should be launched in FY 1999-2000.

#### Monitoring

- Q** *What mechanisms has the State used to monitor the (Family) PACT Program? Is there additional information available describing the monitoring process and the results of any reviews conducted of the (Family) PACT operation over the last two years?*
- A** Currently the State reviews chart abstractions, periodic reports on Health Access Programs (HAP) Card issuance, claims processing data, and claims denials. The reports are reviewed by the fiscal intermediary and presented at a monthly meeting with Office of Family Planning (OFP) Family PACT Program nurse consultants. The nurse consultants determine the appropriate course of action: telephone contact with the provider or a site visit. If there is a site visit, an OFP Family PACT Program nurse consultant conducts a review of patient charts. Also, information on suspected provider billing irregularities is shared among DHS health programs. Providers who are believed to have fraudulently enrolled patients and billed for services are referred to the Department of Health Services' investigative organization, Audits and Investigations Division (A&I). The Waiver proposal contains allocation of additional A&I auditors dedicated to the Family PACT Program for increased monitoring and investigation efforts.

**Q** *Can the state provide more information about the (Family) PACT data collection system? Please describe the Family PACT claims processing system. Will Family PACT providers submit claims through Medi-Cal MMIS?*

**A** Family PACT Program data is collected by the HAP Client Eligibility System and the HAP claims processing system. The HAP Client Eligibility System only receives data on clients who have been determined to be eligible and enrolled in the Family PACT Program. Currently there is no cross reference between the HAP Client Eligibility System client records nor between HAP client records and the Medi-Cal Program data base. However, a proposed system change to facilitate this cross-check is being considered once all Year 2000 changes are completed. In the HAP Client Eligibility System, there is no match of Social Security Numbers (SSNs) or match employing two of the three identifying elements (name, gender, and birth date) as used in Medi-Cal MMIS.

The Family PACT Program HAP claims processing system parallels the Medi-Cal Program claims processing system. Clinician providers are listed on the Provider Master File and must have the appropriate Family PACT Category of Service (COS) on the file in order to be reimbursed for Family PACT services. (This does not apply to pharmacy and laboratory providers.) Services may be rendered by a non-Family PACT enrolled clinician provider only when referred by a Family PACT clinician provider, but the rendering clinician provider must be a Medi-Cal provider.

Family PACT Program claims must utilize the unique primary diagnosis code of "S", whereas the Medi-Cal primary diagnosis code is "V". The Family PACT "S" code system is used to designate family planning as the primary purpose of the visit. Medical and outpatient claims always require a primary diagnosis and must include a secondary and concurrent ICD-9-CM diagnosis code when appropriate. The secondary diagnosis code is reserved for treatment and management of STIs. Reimbursement for procedure codes for Family PACT services is restricted to those procedure codes identified under each method specific to the primary diagnosis code and any related secondary or concurrent condition. All procedure codes are restricted to one per day, same provider, and same patient. Reimbursement is limited to services for women unless otherwise specified. Reimbursement of services to males is limited to those defined by Family PACT for the family planning methods of vasectomy, barrier methods and limited infertility services with HIV screen laboratory testing and STI presumptive treatment for partner management of a reported STI contact.

Like the Medi-Cal claims, the Family PACT Program claims are submitted on the HCFA 1500 Claim Form (hard copy or electronically) and undergo the same edits and duplicate claim audits as Medi-Cal claims. There are over one hundred Family PACT Program

edits and audits. The medical edits review the appropriateness of the service billed based upon age and sex of the patient and the diagnosis code.

Each week, the HAP claims processing system generates a claims report that lists the total number of claims and the total amount paid, medium of claims submission (point of service, interactive voice response, or Internet), number of paid and denied claims according to claim submission medium, and amount paid according to claim submission medium. This report is utilized for monitoring of program expenditures.

When a Family PACT provider renders services to a Medi-Cal eligible, the provider bills the Medi-Cal Program for the services.

**Q     *The application notes on page 14 that more than 600,000 clients were seen in this program statewide. As of January 1, 1999, approximately 1.2 million clients have been enrolled in the Family PACT program. How many encounters were recorded for the 600,000 clients? What is meant by term “enrolled”?***

**A     The 600,000 clientele figure mentioned on page 14 of the Waiver Proposal was the number of clientele seen in the initial eight months of the program’s operation. By January 1, 1999, 1.2 million clients were enrolled and utilized services.**

An encounter is a face-to-face office visit and the number of encounters per client per year varies by the type of the family planning method that the client utilizes. The average rate of encounters per enrollee is nearly two to one. During the State Fiscal Year **1997-1998**, there were about **637,000** clients served during **1,499,596** total encounters. The type of services rendered during those encounters were:

42%	Oral Contraceptives
20%	Contraceptive Injections
1%	Contraceptive Implants
4%	IUDs
21%	Barriers
9%	Pregnancy Testing
1%	Sterilization
1%	Fertility Evaluation

The Family PACT Program client enrollment process is performed by the Family PACT Program clinician providers who are also enrolled as Medi-Cal Program providers by DHS. These enrolled providers review the Client Eligibility Certification (CEC) Form submitted by the potential client (or client whose eligibility certification is expiring).

Eligibility is determined by the provider. The information that is obtained from the CEC Form is transmitted to the *HAP* Client Eligibility System and stored. The clinician providers are able to use their Point of Service device, telephone Automated Eligibility Verification System or the Internet to activate, inquire, update, recertify and decertify clients. If determined to be eligible for the Family PACT Program, the client is certified (or recertified) and receives an activated HAP card. A HAP card is then issued to the client. The client presents the HAP card for authorization for and billing of Family PACT Program services. A client's income, family size and health insurance status are reaffirmed at each visit to the Family PACT Program provider.

**Q** *(Family) PACT collaborates with other programs that serve a similar population. How does the State assure that there is no cost shifting across programs?*

**A** The Family PACT Program has its own clientele or potential clientele in that other programs have fewer clinical service providers, cumbersome enrollment procedures, different eligibility standards, share-of-costs or co-payments, and or violate absolute confidentiality that is required for family planning services.

Medi-Cal clientele cannot participate in the Family PACT Program except when: 1) there is **an** unmet Share-of-Cost (the California term for spenddown) on the date of service; 2) a restrictive service Medi-Cal aid code does not include family planning; or 3) there are confidentiality issues. Confidentiality issues can permit a Medi-Cal client seeking family planning services to be enrolled in the Family PACT Program even though the Medi-Cal client has: 1) full-scope Medi-Cal with no Share-of-Cost; 2) full-Scope Medi-Cal with an unmet Share-of-Cost; or 3) restricted services Medi-Cal (no family planning services). However, if a client presents to a Family PACT provider and divulges that he/she is a Medi-Cal eligible, the Medi-Cal Program will be billed for all Medi-Cal covered services unless the client has indicated/requested confidentiality of services.

Clients covered under third party insurance plans or enrolled in managed care plans or the Healthy Families Program may, just as Medi-Cal clientele, feel the need for confidentiality and request family planning services via the Family PACT Program.

These clients cannot participate in the Family PACT Program except when: 1) there is an unmet deductible (copayment responsibility of the client) on the date of service; or 2) there are confidentiality issues. Since the Healthy Families Program is only for children up through age 18, there are relatively few Healthy Families clientele seeking family planning services.

Services

**Q** *Please describe how reimbursement is made for the additional services.*

**A** Family PACT uses the same billing/reimbursement process as that used by Medi-Cal. Details of this billing system are provided in the PPBI, Section 3 (pages 3-14 through 3-30) and Section 4, enclosed.

Family PACT reimbursement is available only for those services and codes identified by the program. Family PACT has a unique identifier ("S" prefix in the Diagnosis Code field) which identifies family planning services to the claims processing system. A Family PACT "S" code is required to receive reimbursement for each medical and laboratory claim. The Medi-Cal "V" codes are not reimbursable under the Family PACT program. New Family PACT HCPCS Level III codes were created for comprehensive family planning education and counseling services. The higher reimbursement for Family PACT vasectomy services is billed using the unique "S" code and a unique vasectomy surgical code.

**Q** *Please provide examples of emergency family planning services.*

**A** Examples of emergency family planning services are included in the PPBI, Section 4c: Family PACT Complication Codes. As indicated, emergency services covered by Family PACT are those directly related to a family planning method. Such emergency services include:

- Complications related to oral contraception: *deep vein thrombosis/ pulmonary embolism.*
- Complications related to Depo-Provera: *management of heavy vaginal bleeding.*
- Norplant complications: *management of insertion/removal site infection, management of insertion/removal site hematoma, management of heavy vaginal bleeding.*
- Complications related to intrauterine device(IUD): *management of pelvic infection, management of perforated/translocated IUD.*
- Tubal ligation complications: *anesthesia complication, abdominal injury, management of operative site or pelvic infection.*

- Vasectomy complications: *management of testicular or spermatic cord hematoma/ hemorrhage, management of acute infection at site of vasectomy.*

**Q** *Please clarify whether there is a standard set of benefits every participating provider must have available. If this is the case, please describe what they are and where the discretion in service provision lie?*

**A** As described in Section 3 of the PPBI, providers are required to directly provide or make available a specific package of comprehensive family planning services. The Family PACT program standards (pages 3-2 through 3-9) specify the scope, type and quality of family planning services required and the terms and conditions under which the services will be reimbursed.

The discretion in service provision by Family PACT providers is based on clinical judgement within the scope of available Family PACT benefits. Program standards do not specify application of particular program benefits to individual client conditions.

**Q** *How are clients informed of the availability of additional program services not offered by their specific provider and referred to a different provider to get them?*

**A** Family PACT program standards require that clinicians must inform clients of all Family PACT program approved contraceptive methods. If the provider organization's clinician staff lack the specialized skills to provide selected procedures, clients must be referred to another qualified clinician provider for these methods/procedures. The clinician must have an established referral arrangement with the other provider(s) when making referrals for these procedures. Please see PPBI pages 3-1 through 3-13, enclosed.

**Q** *Is it the State's intention that all services provided through this program would be eligible for 90 percent federal financial participation (FFP)?*

**A** All Family PACT services are directly related to maintaining comprehensive reproductive health within the context of family planning. On this basis the State anticipates all Family PACT services to be eligible for a 90 percent FFP match.

#### Phase Out Plan

**Q** *Please provide a plan for the phase-out of this demonstration project at the end of five years.*

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- A** A detailed plan for continuing the Family PACT Program will be developed after three years of operation, when viable data is available. When the Family PACT Program Demonstration Waiver terminates, either the United States Congress will have enacted changes to the Medicaid Program to increase the federal poverty limits for family planning services, and the Family PACT Program will continue as a component of the California Medi-Cal Program, or the State of California will resume State-only funding at some monetary level, or the Family PACT Program will cease.

**Budget**

- Q** *Please discuss the justification for the budget assumptions listed. What age range defines a woman "at risk for pregnancy"?*

- A** The range of ages at which women are "at risk for pregnancy" varies as the result of individual biological factors as well as culturally determined factors. However, for purposes of budgeting, California recognizes the "at risk for pregnancy" standard as women who are between ages 15 – 44.

- Q** *What is the effect of the Healthy Families Program on enrollment projections in this program, since children up to age 19, with incomes up to 200 percent of poverty, can be covered through the Healthy Families Program?*

- A** The effect on enrollment projections will be negligible because of the following:
1. The level of enrollment in the Healthy Family Program for ages 15 – 19 is extremely low, less than 2 percent of those eligible.
  2. For those persons aged 15 – 19 who are enrolled in the Healthy Family Program, a large percentage opt to maintain their confidentiality by seeking family planning services outside of the Healthy Family Program.

- Q** *Why is a steady 6 percent projection of unintended pregnancies throughout the 5 years of the demonstration a good number to use when studies show that the rates of unintended pregnancies appear to be decreasing nationally?*

- A** Because of California's demographics and its diverse population mix, the teen pregnancy rate is projected to increase, with at least 82 communities currently identified as having above average rates (see enclosed listing from The California Wellness Foundation).
-

care visit were also more likely to report that they saw the same doctor or health care professional at all or most visits. However, that difference was not statistically significant.

**Convenience of care and enabling services.** The ease with which care can be obtained can have a significant impact on access to care. We consider four measures of ease of obtaining care: <sup>①</sup> whether the time required to travel to the provider is more than 30 minutes; <sup>②</sup> whether the time between **making** an appointment and the date of a visit because of sickness is more than 3 <sup>③</sup> days; <sup>④</sup> whether the time in the office before seeing the doctor is 1 hour or more; and whether the enrollee is able to talk to a medical professional right away when he or she needs medical advice.

As shown in Table 5, we found no evidence that managed care increases the ease of obtaining care or increases the availability of enabling services. Our measure of the availability of enabling services is receiving a reminder call from the provider when a patient is due for a check-up.

However, substantial shares of both the PMAP and FFS enrollees reported travel time to care of 30 minutes or more (18.7 and 21.2 percent, respectively) and waits in the office for care of one hour or more (73.0 and 67.8 percent, respectively). This suggests that there may be general barriers to care in rural Minnesota, which managed care is no better at addressing than FFS.

**Unmet need.** Our final measures of access to care relates to unmet need. We consider unmet need with respect to several different types of care: <sup>①</sup> hospital care, <sup>②</sup> doctor care, <sup>③</sup> care by a specialist, and <sup>④</sup> dental care. We consider two levels of unmet need: needing but not getting care and needing but delaying getting care. We also consider unmet need associated with prescription medicines.

**Table 5**  
**Convenience of Care and Availability of Enabling Services**  
**for PMAP and Medicaid FFS Enrollees Who Visited a Doctor in the Last 12 Months**

Outcome	Unadjusted			Regression-Adjusted			Sample Size †
	PMAP	FFS	Difference	PMAP	FFS	Difference	
minutes or more	17.7	21.6	-3.9	18.7	21.2	-2.4	762
Wait between appointments until next visit is more than 3 days	5.8	5.4	0.3	8.6	8.1	0.5	706
Wait in office before seeing doctor is 1 hour or more	71.2	69.0	2.2	73.0	67.8	5.2	761
Able to talk to medical professional right away when need medical advice	85.8	89.1	-4.0	86.5	88.6	-2.2	816
Provider reminds when due for check-up	39.4	37.5	1.9	55.2	54.4	0.8	745

Source: Survey of Medicaid enrollees in PMAP and Medicaid FFS counties in Minnesota in Spring 1998.

**\*\* (\*\*\*)** Significant at at least the .10 (.05) (.01) level, two-tailed test.

\* Sample size varies because of missing data for the dependent variables for some observations.

**Notes:** Because the samples of PMAP and Medicaid FFS enrollees are not based on random assignment, we provide both unadjusted and regression-adjusted estimates of the differences between PMAP and Medicaid FFS. Our regression-adjusted comparisons control for the effects of other characteristics (demographic and socioeconomic characteristics, health and functional status, health habits and attitudes, and distance from selected health care services).

Ms. Kathleen Farrell  
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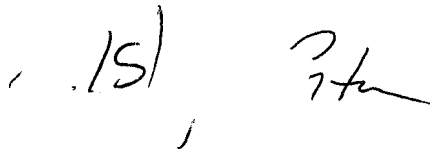
Additionally, California is home to many minority communities who, for cultural, religious, and/or political reasons, tend to reject attempts at birth control education. Examples include: a majority of the large Hispanic population, especially recent immigrants, tend to reject birth control for religious and cultural reasons. The Hmong culture believes that a girl of 15 is ready for marriage and children and encourages this among its youth. California has the largest concentration of Native American population in the U.S., and this population has the highest birth rate of all of the minority populations. These examples all point to a steady number of women being at risk for pregnancy in California over the next five years.

**Q** *Shouldn't equipment costs be \$11,550 rather than \$15,550 ( $\$3,300 \times 3.5\text{FTEs}$ )?*

**A** The extra \$4,000 is for a state-of-the-art laser printer.

We believe that the Department of Health Services has answered the questions raised by the HCFA staff. If you have further questions or require additional information, please contact Ms. Janet K. Olsen-Coyle at (916) 657-0129.

Sincerely,



J. Douglas Porter  
Deputy Director  
Medical Care Services

Enclosure

cc: Mr. Richard Chambers  
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